PROJECT HOPE

Integrating Child Survival and IMCI Activities into Six Target Communities in the North-East Department of Haiti

CS-XVII Cooperative Agreement No. HPF-A-00-01-00031-00

Second Annual Report

Project Location: Department of the North-East, Haiti

Project Duration: September 28, 2001 – September 27, 2006

Submitted to:
U.S. Agency for International Development
GH/HIDN/NUT/CSHGP
Room 3.7-72B
Washington, DC 20523-3700
Attn: Susan Youll

Submitted by:
Project HOPE –
The People-to-People Health Foundation, Inc.
Millwood, Virginia 22646
Tel: (540) 837-2100
Fax: (540) 837-1813

October 2003

Contact person:
Petra S. Reyes, ScD, MPH
Regional Director, Africa and Haiti

Contributors to the writing of this report:

Headquarters:

Robert S. Northrup, M.D.
Senior Technical Advisor

Haiti:

Pierre Despagne, M.D.
Executive Director, CDS

Joanel Mondestin, M.D.
CDS/HOPE Field Project Director

Table of Contents

A. ACCOMPLISHMENTS & ACHIEVEMENTS 1
B. BARRIERS TO PROGRESS 5
C. TECHNICAL ASSISTANCE 7
D. PROGRAM CHANGES FROM DIP 7
E. RESPONSES TO DIP RECOMMENDATIONS AND REQUESTS 7
F. PROGRAM MANAGEMENT 8
G. WORKPLAN 9
H. HIGHLIGHTS 9
I. OTHER RELEVANT PROGRAM ASPECTS 9

Appendices

Appendix 1: Progress in Achieving Project Objectives
Appendix 2: KPC Survey July 2002: Rapid Catch Indicator Results
Appendix 3: KPC Survey July 2002: Univariate Survey Results
Appendix 4: Draft Tri-Partite Agreement
Appendix 5: Workplan

A. ACCOMPLISHMENTS & ACHIEVEMENTS

As noted in the first annual report of this project, actual activities during all of the first year and the first two months of the second year (October and November 2002) had been impeded by first, a lack of personnel related to termination of previous employees and the first project director, and second, inability to reach an agreement between HOPE and CDS, the local NGO working in the other half of the Department of the North-East in health care delivery. During October and November, an agreement was reached, as noted in the year one Annual Report submitted in early December 2002, as quoted below:

- CDSX Director visits Washington area to visit daughter, meets with HOPE VP for International Operations and Senior Technical Advisor; agrees in principle to partnership.
- Results from May-July 2002 KPC received from Haitian survey research firm.
- CDS and MSPP continuing planning discussions, field visits to project sites, making informal assessments.
- HOPE Senior Technical Advisor visits Haiti, meets with USAID, and develops with CDS a six-month agreement to allow initiation of activities by December 1. CDS and HOPE agree to seek conclusion of a long-term agreement by February 28.
- MSH agrees in principle to serve as an in-country agent for HOPE; scope of work currently being negotiated.
- CDS continuing finalization process of project document and proposal to HOPE that will serve as basis for agreement.

With this quote from last year's annual report as the description of the activities that took place in the first two months of the year, the report that follows will describe the project's activities and progress from December 1, 2002 through the end of September 2003.

Hiring of Field Project Director: A previous CDS senior employee, who had resigned in order to pursue elected office in the Cap Haitian area, had become available, and was able to be re-hired by CDS and to begin work on December 1. Dr. Joanel Mondestin had played a key role in the CDS managed health services in the eastern portion of the Department, hence knew many of the DSNE staff as well as the CDS staff very well. As a politician, he also knew many community figures in the area. Hence, he was able to be almost immediately functional personally while awaiting the establishment of a support structure in the region. Since vehicles had already been imported during year 1, he was able to move freely in the area, and begin concrete steps to establish project plans with DSNE.

Establishment of project office in project target location: Thinking initially by the terminated Project Director and in the original proposal was that it would be very difficult to engage staff who were willing to live and work in the project area (Trou du Nord). The newly involved CDS team, particularly the new field director, recognized that a team living in Cap Haitian would be able to spend only 4-5 hours daily working in the project area, an impossible barrier to productivity. Hence the director established the office in TdN, and from the beginning worked from the principle that all employees must live in the project area. This has proven to be an invaluable decision, with staff willing to work long hours to accomplish project tasks.

There were no acceptable accommodations for the office or for living and sleeping for the office employees. It was necessary to contract for a pair of buildings which were only 70% completed.

While completion was initially projected for April 2003, it was May before the office could be occupied, and June for the living quarters. To make these facilities functional, it was necessary to establish facilities for electricity generation (solar and generator) including batteries and an inverter, and for satellite-based Internet and computer communication. To install the telephone and make it functional took three months. This also took substantial time. Additional computers were needed, and took time to arrive. All these factors slowed productivity during the assembly of the various components of the logistical structure. At the same time it became quite obvious that without those logistical bases, productivity and progress were seriously impaired. The project staff concluded that it was a major accomplishment to have opened the office in Trou du Nord, and the staff is in place and living there with sufficient infrastructure to be effective.

Selection of the promoters

Community meetings: From December 2002 to January 2003 meetings were held with community leaders and organizations, including representatives of churches, from the two communes planned for initiation of project activities, Trou du Nord and Terrier Rouge. Project staff explained to them the objectives of the project and requested them to propose members of the community as promoters, based on the following criteria

- Woman or man age 25 to 40 years old;
- Living in the locality (zone and sector);
- With at least the second year of Secondary school and no more than 3rd year;
- Being available every day of the week for health activities;
- Have a good reputation in the community.

Interviews with candidates: Interviews were held with each candidate in order to identify the ones who met the criteria. Thirty eight (38) promoters were selected (25 for the commune of Trou du Nord and 13 for the commune of Terrier Rouge).

Additional assessments

Census: To facilitate analysis of the population and to enable identification of houses as part of strategic planning and supervision, a census was carried out in February with the assistance and expertise of the Haitian Institute of Statistics and the collaboration of members of the community. Maps of the two communes were prepared (TdN and TR), all houses were numbered, and population groups were defined by sex and age group: TR and TdN. Population breakdowns are as follows:

Terrier Rouge -- 5144 houses

Age	**Quantity**	Age	**Quantity**	Age	**Quantity**	Age	**Quantity**
0-5	**3153**	20-24	**1992**	40-44	**884**	60-64	**525**
6-9	**2353**	25-29	**1451**	45-49	**786**	65-69	**416**
10-14	**2720**	30-34	**1207**	50-54	**763**	70 et +	**1135**
15-19	**2419**	35-39	**926**	55-59	**556**	**TOTAL**	**21,286**

Trou du Nord -- 9100 houses

Age	**Quantity**	Age	**Quantity**	Age	**Quantity**	Age	**Quantity**
0-5	**5767**	30-34	**1992**	40-44	**1596**	60-64	**870**
6-9	**4175**	35-39	**1631**	45-49	**1194**	65-69	**555**
10-14	**4675**	20-24	**2948**	50-54	**1416**	70 et +	**1569**
15-19	**3952**	25-29	**2362**	55-59	**790**	**TOTAL**	**35,492**

Service Delivery and Management Assessment (SDMA): The current state of the DSNE facilities and services (capacity assessment) was assessed using a tool developed by MSH for its work in Haiti and elsewhere, the SDMA. A team of MSH, CDS, and DSNE assessors visited each of the health centers and dispensaries in the project district, and assessed the following aspects :

General aspects	Organization of community	Information system and
Child survival	services	general management
Reproductive health	Behavior change	Human resource management
STIs/HIV/AIDS	Communication	Financial management
Tuberculosis	Drug and supply logistics	

Use of this tool results in an Action Plan, not a simple report. This Action Plan describes the finding needing attention, the activity needed to correct the situation, the person or group responsible for carrying out the action, and the target date for its completion. The findings range from deficiencies in facilities, in equipment, in supplies and drug logistics, in various realms of management and in M&E. The project is now in the process of organizing these individual directives into plans, which will lead to carrying out the actions set by this capacity assessment. These actions will be major inputs to capacity development for the DSNE by the project.

Training:

Promoters and government Health Agents: As of this report, training as well as selection of promoters and HAs had been focused on the initial two communes of the six communes ultimately targeted by the project. Promoter selection and training in the remaining four communes will begin in November 2003. For the initial communes, promoter training commenced with their preparation to carry out the census in their communes. The training included preparation of the teams which would carry out the census, including team supervisors and team leaders. These lessons were immediately applied in the implementation of the census. Subsequent training has covered IMCI and the HIS of the project and government.

This was followed by training of the promoters and the government health agents in immunization, and participation by them in a "mopping up" immunization campaign aimed at increasing coverage in the target communes. During these door-to-door efforts, the promoters were supervised by the nurses involved in the immunizing activities.

Subsequently promoters began to participate in rally posts and fixed point sessions in their communities, and to work in health centers and facilities in supporting patient care there, with on-the-job training by supervising auxiliaries. Formal training in IMCI, beginning with diarrhea and pneumonia and in tuberculosis and community mobilization (curricula from the Haitian government), will commence in November 2003.

Auxiliaries and Nurses: Auxiliaries and nurses from the total project area have received initial training in IMCI using the Government's curricula. Implementation is proceeding slowly, however, due to deficiencies in drugs and supplies. The project will reinforce this training during year three of the project.

HOPE/CDS staffs are working with both promoters and auxiliaries to facilitate and support implementation of the training during supervision visits.

Fixed Points and Rally Posts: The project will deliver community services at regular outreach sessions organized by the promoters with the community. These will include preventive services to mothers and children. A wider range of services can be provided at Fixed Points where provision has been made for examination of pregnant women and women seeking to initiate

Family Planning in privacy. Those places have been selected in the two initial communes, and with the preparation of the promoters for their community mobilization and service roles, they will begin to be used regularly to provide these services.

Information system: The project is using both the MOH's standard information system and a supplementary project system to track activities and outcomes, in order to ensure during the initial implementation phase while the MOH system is still functioning poorly the availability of valid and reliable data. The project statistical section has carried out the following actions:

- established project hardware and software infrastructure;
- prepared curricula for training of promoters and staff facilitators;
- designed forms or adapted from existing CDS protocols forms for recording and collection of community, facility, and project data, all in collaboration with the DSNE;
- programmed databases on Excel to receive monthly statistics from health system and from project activities; and
- developed tools for analysis of data.

The system is now inputting data from the various sources.

Contributing factors which supported progress:

These include the following:

- CDS experience and expertise: CDS's long tenure in the North-East in health services delivery, its existing partnership with DSNE although on a different basis, its knowledge of MSH tools (e.g. SDMA) and monitoring and reporting procedures and indicators, and its experience in meeting performance targets in the NE health system, were invaluable in allowing progress to be made from the moment the initial interim agreement was signed.
- The specific skills of Dr. Joanel Mondestin, the Field Project Director, and Dr. Pierre P. Despagne, the CDS Executive Director, have been equally critical to project progress. Dr. Mondestin's network of colleagues in the North and North-East Departments, his in depth field experience in delivering services in the North-East via the government's health facilities, and his solid judgment and practical public health experience have facilitated much more rapid project progress than would have been possible without him. Dr. Despagne has provided the necessary guidance and managerial and problem solving support to Dr. Mondestin, and been flexible with financing and other resource provision, allowing project activities to continue even when money failed to flow from HOPE to Haiti. His judgment on matters of relationships and strategic approaches has allowed the project to navigate some difficult political waters safely.
- The availability of a strong base of technical assistance to the project in the CDS headquarters in Port au Prince, in the form of Dr. Lionel Barthelmy and Dr. Evelyne Ancion Degraff, have allowed the project to proceed with existing curricula and data forms needing only slight modification for application. These CDS staff members have played critical roles in the training activities carried out so far, and in the design of the monitoring and evaluation activities of the project, and have been made readily available to project needs when needed. This has allowed successful training and census activities, the SDMA, and other critical activities to be carried out in a timely manner, with only minimal design and preparation time, so that this already shortened project can meet – or come close to meeting – its stated schedule of activities.

A table showing progress of the project in achieving the objectives set in the DIP is provided as *Appendix 1*.

B. BARRIERS TO PROGRESS

The project has experienced a wide variety of barriers to progress, many of which can be attributed ultimately to the challenges of the project and CDS needing to work with and through the MOH, both at national level and at departmental and UCS level. These barriers include:

- *DSNE reluctance to participate fully as activities implementer and full partner:* For a variety of reasons which vary according to the level in the health system of the persons involved, both staff and leadership of the health system have been reluctant to accept the model of this project, in which DSNE is the implementer of the project and CDS/HOPE provides support. The nurse responsible for one of the two UCS areas has resisted the project's activities from the outset, refusing to attend meetings, participate in training sessions, or go out from the health center in which she works to supervise or participate in activities of those for whom she is responsible. Trainers from DSNE have participated in training activities only reluctantly and incompletely, and the Departmental Chief Medical Officer is absent from the Department and his job more than half the time. This led to a decision to stop training activities until the roles and responsibilities of each of the organizational partners and individual staff persons could be reviewed, and agreements reached to ensure adequate participation by the needed staff from various levels, including the top. Training resumed, but there continues to be the attitude that the project belongs to HOPE and CDS, and the DSNE and UCS senior staff can do other things other than participate in project activities.

  Action being taken is to pursue formal agreement via the Tri-Partite agreement regarding roles and responsibilities, to negotiate in advance roles of critical DSNE persons in project activities, and to cajole, threaten, and in other ways seek to attract participation of these staff members. No simple long-lasting solution has so far become evident.

- *Promoter reluctance to accept the DSNE rate of pay*: Led in part by the aforementioned UCS nurse, promoters from one UCS decided to strike during the census for higher pay. Individual interviews with each promoter led to their agreement to return to work, but the salary issue continues to threaten their enthusiastic participation in project activities. This in turn makes less dependable the critical village level activities leading to empowerment upon which community level sustainability depends.

  Action being taken is to enhance the level of project interaction with the promoters, to provide active motivation and encouragement, and to consider the provision of salaries at the slightly higher level of CDS Health Agents in the neighboring portion of the Department.

- *Delayed flow of funds from HOPE to CDS*: The difficulties described with DSNE have made it difficult to reach agreement with DSNE regarding the project as a whole. DSNE has seen it useful to use the withholding of its signature as a tool to force the project to shift additional resources to DSNE. This has caused CDS to be reluctant to make contractual commitments to HOPE for delivery of defined actions and results, since CDS has been unable to be sure that DSNE will keep its part of the bargain. This lack of signature by CDS ultimately led to a situation where HOPE financial managers were unwilling to release further funds without a

legal contract. This resulted in a temporary halt to other than basic project activities (no training activities, no further outreach, etc) until these agreements can be reached. We are waiting on events to happen later this week (Friday Oct 31) to see if we will be able to obtain the needed signatures and proceed with transfer of funds, which will in turn allow the planned activities to begin again.

Action beyond what has been done may not be necessary. It appears, however, that it is inappropriate for HOPE and CDS to expect substantial involvement by DSNE in the project. This may lead to replanning of project activities and measures to enhance sustainability.

- *Lack of community infrastructure*: The Trou du Nord area is extremely rural, with very poor roads, simple primitive buildings, and little or no electricity or telephone infrastructure. This caused the establishment of an office and a residence for project staff, as well as the recruiting of project staff, to be very difficult and time-consuming. Project leadership had to divert major chunks of time and attention to solving construction and procurement issues, and efficient project operations were impossible until May 2003 when the office could be occupied. Inefficiency extended to the field director having to drive two hours to Cap Haitien to visit an Internet Café with painfully slow communication rates in order to communicate painfully slowly with CDS in Port au Prince or HOPE. Even now, with the establishment of basic office infrastructure in Trou du Nord, a heavy rainstorm will prevent the dish from communicating with the satellite, and prevent any email communication.

  Action aimed at further improvements in infrastructure appears to be impossible. The project will need to specifically consider whether these inefficient working situations will allow achievement of all the activities and objectives in the rather ambitious DIP.

- *Theft of a vehicle and the project computer*: Thievery is common in Haiti, and the Field Director was stopped in an isolated area, the car stolen, and his laptop computer taken. Despite automatic engine shutoff, the thieves managed to start the car and drive off. Neither the car nor the computer had been seen again. Both these losses have been difficult for the project. With only one additional (old) computer at the time, Dr. Mondestin had not been regularly backing up his computer, and many plans and documents critical to the project were lost at the time. The reduction of the project transport by one vehicle has severely hampered the efficient carrying out of critical project activities. One vehicle had been demanded by the DSNE Medical Director, and the project had decided to "lend" that vehicle at the time. Now, one vehicle short, the project has asked for the loaned vehicle back, to allow meetings, field visits, supervision, educational programs and training, and other elements of project implementation to continue at a reasonable pace, but so far DSNE has shown no sign of willingness to release the vehicle. This again threatens the efficiency of the project and its ability to complete its planned range of activities within the time period remaining in the project.

  Action will continue to seek to obtain the return of the loaned vehicle. All computers are now backing up their work regularly, especially those on laptops which move about in cars. HOPE was able to provide the Field Director with an earlier model computer to substitute for the stolen machine.

  All these barriers threaten the ability of the project to complete its planned activities in the time available. We anticipate that by the end of the first quarter in 2004 it will be possible to envision more accurately what level of activity will be possible to ensure for the project. We will formally consider at that time the project design and the planned

activities and reach a decision as to whether to continue with the full range of activities and objectives, or to reduce them in order to better match the likely productivity of the project team and its DSNE "partners."

C. TECHNICAL ASSISTANCE

The needs for TA are both in the area of innovative monitoring and evaluation, specifically in development of the LQAS and VCR (Verbal Case Review) methods. HOPE HQ has planned from the beginning to provide this TA, and the first training will take place on November 6, 2003.

D. PROGRAM CHANGES FROM DIP

There are no significant program changes from the DIP submitted June 30, 2003. The project continues to plan all of the activities described in the DIP narrative and the DIP Workplan table. As noted in the table of Progress in Achieving Project Objectives in *Appendix 1*, some delays in the implementation of certain planned activities have occurred, but we do not anticipate that these delays will prevent the ultimate completion of any of the planned activities

E. RESPONSES TO DIP RECOMMENDATIONS AND REQUESTS

The recommendations made at the Mini-University Review of the Project DIP were all, with two exceptions, with regard to requests for additional information to be provided in the final DIP to be submitted 30 June 2003. These requests were responded to in that submitted DIP.
The first exception was a request for complete KPC data. The completed Rapid Catch indicator results were supplied with the DIP. In July, the remaining indicators were analyzed as much as possible, given the nature of the questions used in the survey. The results are provided in *Appendices 2 and 3*.

The second exception was the request to "document the interim and final "tri-partite" agreement for the life of the project, to be submitted with this Annual Report at the end of October. As already noted in the Barriers to Progress section above, reluctance by DSNE to accept the limitations of the project finances and ability to provide for DSNE deficiencies in equipment, transport, and salary supplements have to this time not allowed HOPE and CDS to obtain final signatures on either the HOPE-CDS contract or the Tri-Partite agreement between the MOH and DSNE, CDS, and HOPE. The HOPE-CDS contract is awaiting only the signature of the CDS Director, Dr. Boulos, who has been out of the country but has reviewed previous drafts of the agreement and has had no objections to them, hence should be able to sign while he is in the States in early November. The Tri-Partite agreement will be discussed among DSNE, national level MOH, and CDS on Friday October 31, 2003 in Port au Prince, and it is expected that the MOH will sign the document at that time. When these signatures are obtained and the agreements finalized, we will submit the final signed documents to USAID. In the meantime, we attach as *Appendix 4* the draft Tri-Partite agreement which is currently being considered by the Haitian government, hopefully to be signed on October 31, 2003.

F. PROGRAM MANAGEMENT

Management of the project has had to deal with two management structures, the Project HOPE management structure in Millwood, Virginia, and the CDS management structure in Port au Prince and Trou du Nord.

Financial Management: CDS is a well-running organization with long experience in financial reporting according to USAID guidelines, and their accounts have been timely, complete, and accurate. Movement of funds within Haiti from Port au Prince to the field has taken place smoothly. The difficulties in reaching contractual agreement created temporary funding shortages due to non-transfer of funds form HOPE to CDS, a situation which we hope will be dispelled shortly. CDS finances are preparing for annual audit by USAID. There have been no financial management issues regarding this project within HOPE headquarters.

Human Resources Management: The project has followed CDS standard HR procedures in hiring staff and setting salaries. Project HOPE was requested by the USAID mission in Haiti to have some of the project staff on direct HOPE salaries, and for them to report to HOPE in addition to their reporting to the Field Project Director and CDS. For expediency, all field staff were hired initially by CDS, and have been reporting through customary CDS reporting channels, while the Field Project Director, formally a CDS employee, communicates and reports directly to the Senior Technical Advisor and Regional Management Team at HOPE Center, as well as to CDS management. HOPE and CDS are working to develop mechanisms which will be advantageous to both employees and to the project and which will respond to USAID's request. As this is being worked out, all the employees are working productively on project activities, about which information is being communicated to HOPE and from HOPE back to the field. The Field Project Director and the senior field administrator both attended the HOPE Leadership Conference in September 2003 in Millwood, and the project is planning training activities for staff in their areas of activity.

Technical Management: The HOPE Senior Technical Advisor, Dr. Northrup, is in constant communication with Dr. Joanel Mondestin in the field and Dr. Pierre Despagne in Port au Prince regarding technical matters, and Dr. Northrup has gone to Haiti on several occasions in the past 12 months for the purpose of advancing the technical activities of the project. These three worked very closely in assembling the Detailed Implementation Plans for the project and in responding to USAID's recommendations for revising them. Dr. Northrup both responds to technical requests from the field, and pushes the field team in technical areas needing additional attention. Both sides would like to have additional communication in both directions, but it appears as if the level of interaction has so far been sufficient to mount the planned activities with satisfactory technical direction and skill, based a great deal on the great competence within the CDS organization. A system of six weekly written reports has been in place since the beginning of the project, and has during most periods functioned effectively in identifying issues and defining progress.

Partner Relationships: This report has already emphasized the challenges of CDS and HOPE in dealing with MOH and DSNE. Relationships between CDS and HOPE have been excellent in all ways except for reaching formal agreement. That difficulty has led to HOPE withholding funds, leaving CDS to initially support activities from its own reserve, and eventually to stop all

but basic minimal project activities, while awaiting agreement and resumed flow of funds. This has frustrated all of us working with this project, but seems to be solved.

Capacity Assessment and Response: We have already mentioned the SDMA (Service Delivery and Management Assessment) carried out by CDS on the facilities and management in the project area. As noted, the project is working to respond to the recommendations and specific actions requested in the report of that activity, both as part of the training and service support activities associated with delivery of services to the target population, and as additional non-integrated actions. A review of progress in carrying out these actions is scheduled for one year following the SDMA, in the first quarter of 2004.

G. WORKPLAN

The proposed workplan is provided as *Appendix 5*.

H. HIGHLIGHTS

The project has no highlights to report at this point.

I. OTHER RELEVANT PROGRAM ASPECTS

No other aspects of the program seem necessary to include in this report.

Appendix 1

PROGRESS IN ACHIEVING PROJECT OBJECTIVES

Objective	On target (Yes/No)	Comments
Child Health – Household Level		
#1: Improved preventive actions to maintain child health	Yes	Rally posts and fixed points selected, some initiated. Supervision of promoters not initiated
# 2: Improved home management of common childhood illnesses	Yes	
# 3: Improved care-seeking practices	Yes	
Child Health – Community Level		
# 4: Increased community participation in child health and disease prevention activities	Mostly yes	Rally post supplies and equipment from MOH delayed. Animatrice activities to begin '04
Child Health - Health Facility Level		
# 5: Improved management of child health and community outreach	No	Auxiliary training only partially completed, supervision methods and training in development; VCRs to begin '04
Child Spacing		
# 6: Improved knowledge and practices	No	FP training not begun, community/CBD mobilization confined to promoter efforts; colored charts being initiated; mother/father clubs not scheduled until 2/04
# 7: Increased community participation	Yes	
# 8: Improved access and quality of services	Yes	
HIV/AIDS/STIs		
# 9: Improved knowledge and practices	Yes	
# 10: Increased community participation	Yes	
# 11: Improved access and quality of services	No	STI training delayed for half of auxiliaries; routine drug supply monitoring not yet initiated; depot activities pending
Pregnancy and Delivery Management		
# 12: Improved knowledge and practices	No	IEC training for auxiliaries being developed; expanded auxiliary services not yet initiated, hence no quality monitoring or consequent improvement
# 13: Improved access and quality of services	No	TBA inventory delayed until January '04, before training sessions.
Capacity Building -- HOPE		
# 14: HOPE management and technical expertise strengthened	Yes	
Capacity Building and Sustainability		
# 15: Community Level	No	Auxiliary supervision training delayed until Jan '04
# 16: Health Facility Level	No	Improved services not yet initiated, due to delays in supply and equipment provision by MOH
# 17: UCS and Departmental level MOH	Yes	
# 18: CDS	Yes	

Appendix 2

Haiti Child Survival Program

KPC Indicators

July 2002 Survey

Prepared July 29, 2003

Indicator	Num	Dem	Coverage Estimate (%)	C.I.[1] ± %
1. **Full Immunization**--% of children 12-23 months who have received all required vaccinations (polio3, DPT3, measles) by their first birthday, card confirmed [2]	0	0	0[3]	N/A
2. **Vitamin A Coverage**--% of children 12-23 months who have received Vitamin A in the past 6 months	114	590	19.3	6.3
3a. **Tetanus Toxoid Coverage**--%of mothers with children 0-23 months who received at least two doses of TT during pregnancy, card confirmed [2]	65	590	11.0	5.0
3b. **Tetanus Toxoid Coverage**--% of mothers with children 0-23 months who received at least two doses of TT before birth of last the youngest child [4]	75	590	31.4	7.4
4. **ORS**--% of mothers have an ORS packet (*Sei Lavi*) at home [5]	-	-	-	-
5. **Exclusive Breastfeeding**--% of infants 0-5 months who have received only breastmilk in past 24 hours [2]	82	185	44.3	14.3
6. **Growth Monitoring**--% of children 0-23 months who were weighed in past 4 months, card confirmed [6]	-	-	-	-
7. **ORT Use During Diarrheal Episode**--% of children aged 0-23 months with diarrhea within past two weeks who received oral rehydration solution [5, 7]	155	277	56.0	11.6
8a. **Danger Signs of Dehydration**--% of mothers of children aged 0-23 months who can name at least two signs of dehydration	229	590	38.8	7.8
8b. **Preparation of ORS**--% of mothers with children 0-23 months who know how to prepare ORS correctly [5, 8]	-	-	-	-
9. **Continued Feeding During Illness**-% of mothers with children 0-23 months who report giving their child increased fluids and continued feeding during child's last illness episode in the past two weeks [2]	58	392	14.8	7.0
10. **Follow Prescribed Treatment**--% of mothers with children 0-23 months who know how to complete prescribed treatment to the child following a prescription by a provider [9]	-	-	-	-
11. **Continued Feeding During Illness**--% of mothers with children 0-23 months who report increased number o f meals to a child recovering from illness within the past two weeks [6]	-	-	-	-
12. **Health Seeking Behavior for Sick Child**--% of mothers with children 0-23 months with illness within the past two weeks who took their children to a facility for treatment	206	392	52.6	9.8
13. **Return for Care**--% of mothers with children 0-23 months who can explain when to return to the health facility for follow-up for a sick child [9]	-	-	-	-
14. **Use of Modern Method of Family Planning**--% of non-pregnant mothers with children 0-23 months who desire not more children in the next two years, or are not sure, who are using a modern method of family planning [2, 10]	-	-	-	-
15. **Knowledge of Family Planning Methods**--% of women with children 0-23 months who can name at least two modern methods of FP	371	590	62.9	7.7

Indicator	Num	Dem	Coverage Estimate (%)	C.I.[1] ± %
16. **Adequate Birth Spacing**-% children 0-23 months born at least 24 months after previous surviving child [2]	185	303	61.1	10.9
17. **HIV/AIDS Prevention**--% of mothers with children 0-23 months who can name at least two ways to avoid HIV/AIDS[2, 11]	312	590	52.9	8.0
18. **Condom Use**--% of women with children 0-23 months whose partner used a condom during last intercourse [6, 11]	-	-	-	-
19. **Sexually Transmitted Infections**--% of mothers with children 0-23 months who can name at least two signs that indicate an STI in a woman [11]	212	590	35.9	7.7
20. **Treatment Seeking for STIs**--% of women with children 0-23 months who seek treatment for an STI at a facility [6, 9,11, 12]	-	-	-	-
21a. **Pregnancy Danger Signs**--% of mothers with children 0-23 months who can name 3 or more danger signs during pregnancy [13, 14]	38	590	6.4	0.7
21b. **Postpartum Danger Signs**--% of mothers with children 0-23 months who can name 2 or more danger signs postpartum[6]	-	-	-	-
22. **Prenatal Care**--% of mothers with children 0-23 months who received 3 or more prenatal exams, card confirmed	41	90	45.6	20.5
23. **HIV/AIDS Test**--% of women with children 0-23 months who know where to go for an HIV/AIDS test [5, 15]	-	539	-	-
24. **Trained TBAs**--% of mothers with children 0-23 months whose home birth was assisted by a trained TBA [16]	-	-	-	-
25. **Clean Birth Kit Use**--% of mothers with children 0-23 months whose birth involved a clean birth kit	220	511	43.1	8.5
26. **Postpartum Vitamin A**--% of mothers who received Vitamin A within 7 days of giving birth [17]	35	590	5.9	0.7
27. **Postpartum Promoter Visits**--% of women with children 0-23 months visited at home by promoter within 7 days of birth[18]	1	13	7.7	4.5
28. **Postpartum Institutional Visits**--% of women who visit an institution within 7 days after giving birth	132	590	22.4	6.7
Rapid Catch Indicators [19]				
1. **Underweight**-% children 0-23 months < -2 SD weight for age	75	590	12.7	5.4
3. **Skilled Attendant**-% of mothers with children 0-23 months who had a doctor or nurse/auxiliary nurse in attendance at birth	61	588	10.4	4.9
5. **Exclusive Breastfeeding**-% of infants 0-5 months fed only breastmilk in past 24 hours	82	185	44.3	14.3
6. **Complementary Feeding**-% of children 6-9 months who received breastmilk and complementary foods in past 24 hours	51	87	58.6	27.0
8. **Measles Vaccine Coverage**-% of children 12-23 months who received a measles vaccine, card or verbally confirmed	121	234	51.7	12.8
9. **Child Bednet Use**-% of children 0-23 months who slept the previous night under a treated bednet	24	590	4.1	3.2

Indicator	Num	Dem	Coverage Estimate (%)	C.I.[1] ± %
11. **Handwashing-%** of mothers with children 0-23 months who wash their hands before eating, before feeding child, after defecating, after attending a child who has defecated	38	590	6.4	3.9
12. **Mother's Knowledge of Danger Signs**-% of mothers with children 0-23 months who can name at least two danger signs of childhood illness that indicate need for treatment	360	590	61.0	7.9

[1] CI = ± 2 * 1.96 √(p*q)/n)

[2] Rapid Catch indicator

[3] 6.8% of children are fully immunized, by verbal recall

[4] Combination card confirmed and verbal recall

[5] Input from the field needed to define 'correct' response categories

[6] Required data for this indicator not collected at baseline; requires amendment of KPC questionnaire to capture data for this indicator

[7] 'ORS' (from Q. ME9) includes ORS packet, home ORS solution, or 'other ORS solution' (Pedialyte)

[8] For this indicator, was a demonstration necessary required or done by the mother? It appears that there are questions on the right hand side of Q. SRO3, but it is unclear how the response fields on the left side related to those on the right.

[9] Data to be captured by other means than KPC survey; consider time frame of illness within past two weeks

[10] Question related to a time frame (two years) for not wanting a/another child must be added to make the indicator the standard Rapid Catch indicator. Among those women who are not pregnant (n=534) and do not wish to have another child (n=456), 19.5% (n=82) are using a modern method of FP. Out of the whole KPC population (n=590), 16.6% (n=98) are using a modern method.

[11] Data collected for women only.

[12] Will treatment occur only at facilities, or are other places considered 'correct'?

[13] Consider adding more 'correct' choices to KPC Question GR3

[14] The % of mothers with children 0-23 months who can name at least 2 danger signs during pregnancy is 22% (n=130) out of the population (n=590).

[15] Where to go for HIV/AIDS test: 81.3% (n=438) mentioned hospital, 16.7% (n=90) mentioned health post or center, and 0.7% mentioned VCT center.

[16] 'Trained TBA' not indicated in survey; it is assumed that 'TBA with box' is a trained TBA, but this is not clear. Among those women who have had a home birth (n=510), 60.6% (n=309) were assisted by a TBA with 'a box'.

[17] Only includes women with cards: timeframe (within 7 days) not asked of women using verbal recall.

[18] When considering either the TBA or the promoter, the results are much higher: 95% of women (n=230) have a home visit from a TBA or a promoter within 7 days after birth, out of a population of 242 women who gave birth at home.

[19] Includes only those Rapid Catch indicators not listed in first section. The numbering is consistent with the standard numbers for the Rapid Catch Indicators.

Appendix 3

Haiti Child Survival Program

KPC Survey July 2002: Univariate Survey Results

Prepared August 4, 2003

Indicator	Num	Dem	Point Estimate (%)	Std. Dev.+ / C.I.*[1]
Basic Demographic Characteristics (N=590 Mothers with youngest child < 2 years)				
Characteristics of mother				
Age, education, number of children, work for income:				
Mean age (range 15-55)[2]	-	-	27.8	7.9 +
Number of years attended school (range 0-16)	-	-	3.6	3.7 +
Number of biological children < 5 years[2] (range 1-4)	-	-	1.6	0.6 +
Works to earn money inside the home	72	590	12.2	-
Works to earn money outside the home	104	590	17.6	-
Characteristics of child				
Age of child (in months):				
0-3	90	590	15.3	-
4-6	95	590	16.1	-
7-11	113	590	19.2	-
12-18	141	590	23.9	-
19-24	73	590	12.3	-
Prenatal Care and Delivery				
Type of provider sought for prenatal care:				
No one	142	590	24.1	-
Doctor, nurse, nurse auxiliary/ Health facility	432	590	73.2	-
TBA	6	590	1.0	-
Health agent	10	590	1.7	-
Number of prenatal visits (to any type of provider):				
0	145	590	24.6	-
1	54	590	9.2	-
2	84	590	14.2	-
3 or more	307	590	52.0	-
Mean number of visits	-	-	**2.7**	2.2 +
Knowledge of danger signs during pregnancy:				
Fever	185	590	31.4	-
Difficulty breathing	49	590	8.3	-
Bleeding	161	590	27.3	-
Swollen ankles	122	590	20.7	-
Can mention at least two danger signs	130	590	22.0	0.6*
Can mention at least three danger signs	38	590	6.4	0.7*
Location of birth:				
Home	511	590	86.6	-
Home of TBA	11	590	1.9	-
Health facility	62	590	10.5	-
Type of birth attendant:				
No one	8	590	1.4	-
Doctor	37	590	6.3	-
Nurse/nurse auxiliary	24	590	4.1	-
TBA	170	590	28.9	-
TBA 'with box'	321	590	54.6	-
Health agent	5	590	0.9	-

Indicator	Num	Dem	Point Estimate (%)	Std. Dev.+ / C.I.*[1]
Family member	18	590	3.1	-
Use of clean birth kit during delivery	242	590	**41.0**	0.8*
Maternal card in possession	133	590	**22.5**	0.7*
Number of prenatal visits, card confirmed:				
None	503	590	85.3	-
1	17	590	2.9	-
2	26	590	4.4	-
3 or more	44	590	**7.5**	0.4*
Mean			**0.4**	1.4+
Number of tetanus toxoid vaccines, card confirmed:				
0	477	590	80.8	-
1	48	590	8.1	-
2 or more	58	590	**9.8**	0.4*
Mean			**0.3**	0.7+
Post partum				
Type of provider at first postpartum check:				
No one	278	590	47.1	-
Doctor	24	590	4.1	-
Nurse/nurse auxiliary	44	590	7.5	-
TBA	229	590	38.8	-
Health agent	13	590	2.2	-
Number of days after delivery first postpartum check:				
No postpartum check	299	590	50.7	-
1	98	590	16.6	-
2	91	590	15.4	-
3	82	590	13.9	-
4 or more	20	590	3.4	-
Mean			**1.0**	1.3+
Facility checkup postpartum:				
No	356	590	60.3	-
Yes	234	590	**39.7**	*
Number of days after delivery checkup at facility:				
0	351	590	59.5	-
1	10	590	1.7	-
2	29	590	4.9	-
3	57	590	9.7	-
4	11	590	1.9	-
5	11	590	1.9	-
6	6	590	1.0	-
7	8	590	1.4	-
8 or more	107	590	12.0	-
Mean number of days checkup after delivery			5.1	12.8+
Currently pregnant:				
No	534	590	90.5	-
Yes	50	590	8.5	-
Unsure	5	590	0.8	-
Wants another child:				
No	456	590	77.3	-
Yes	134	590	22.7	-
Family Planning				
Knowledge of Family Planning:				
Knows no method	81	590	13.7	-
Condom	116	590	19.7	-
Female condom	15	590	2.5	-
Vaginal creams/jellies	1	590	0.2	-

Indicator	Num	Dem	Point Estimate (%)	Std. Dev.+ / C.I.*[1]
Tablets	14	590	2.4	-
Diaphragm	9	590	1.5	-
Pills	374	590	63.4	-
Depo-Provera	450	590	76.3	-
Norplant	346	590	58.6	-
IUD	7	590	1.2	-
Female sterilization	64	590	10.8	-
Vasectomy	37	590	6.3	-
Periodic abstinence	4	590	0.7	-
Withdrawal	13	590	2.2	-
Menstrual regulation	13	590	2.2	-
Total abstinence	6	590	1.0	-
LAM	18	590	3.1	-
Can name at least one method	495	590	83.0	0.6*
Can name at least two methods	371	590	**62.9**	0.7*
Current Use of Method:				
Not using a method	362	590	61.4	-
Condom	5	590	0.8	-
Female condom	1	590	0.2	-
Vaginal creams/jellies	0	590	0.0	-
Tablets	0	590	0.0	-
Diaphragm	0	590	0.0	-
Pills	23	590	3.9	-
Depo-Provera	54	590	9.2	-
Norplant	14	590	2.4	-
IUD	0	590	0.0	-
Female sterilization	3	590	0.5	-
Vasectomy	0	590	0.0	-
Periodic abstinence	1	590	0.2	-
Withdrawal	7	590	1.2	-
Menstrual regulation	5	590	0.8	-
Total abstinence	2	590	0.3	-
LAM	4	590	0.7	-
Currently using a method	98	590	**16.6**	0.6*
Breastfeeding and Nutrition				
Ever breastfed	582	590	**98.6**	0.0*
When baby was first put to breast:				
Right after birth	335	590	**56.8**	0.8*
Same day	62	590	10.5	-
1 day later	80	590	13.6	-
2 days later	30	590	5.1	-
More than 2 days later	77	590	13.1	-
Currently breastfeeding	508	590	**86.1**	*
Number of meals/snacks yesterday (mean) (range 3-25)			**9.1**	3.6[+]
Nutritional Status:				
Moderate malnutrition (underweight < -2 SD)	75	590	**12.7**	0.5*
Severe malnutrition (underweight < -3 SD)	21	590	3.6	0.3*
Growth Monitoring Card possession	384	590	**65.1**	0.7*
Immunizations				
Had at least (card confirmed):				
1 dose BCG vaccine	205	590	34.7	*
3 doses of polio vaccine	118	590	20.0	*
3 doses of DPT vaccine	93	590	15.8	*
1 dose measles vaccine	114	590	19.3	*
1 does of Vitamin A within the past 6 months	47	590	8.0	*

Indicator	Num	Dem	Point Estimate (%)	Std. Dev.+ / C.I.*[1]
Had at least (combined card confirmed and verbal):				
1 dose BCG vaccine	284	590	48.1	-
3 doses of polio vaccine	156	590	26.5	-
3 doses of DPT vaccine	127	590	21.5	-
1 dose measles vaccine	178	590	30.2	-
1 does of Vitamin A within the past 6 months	114	590	19.3	-
Prevention of Malaria				
Bednet(s) in household	114	590	19.3	-
Person(s) who slept under bednet last night:				
Mother	80	590	**13.6**	0.5*****
Child < 24 months	111	590	**18.8**	0.6*
Bednet treated in household	24	590	4.1	-
Sick Child				
Knowledge of danger signs of illness indicating need for treatment:				
Looks unwell, sadness	103	590	17.5	-
Lack of appetite or thirst	178	590	30.2	-
Weakness, unable to get up	35	590	5.9	-
Fever	502	590	85.1	-
Difficulty breathing	6	590	1.0	-
Vomiting	241	590	40.8	-
Convulsions	28	590	4.7	-
Skin eruptions, itching, rash	189	590	32.0	-
Headache	128	590	21.7	-
Abdominal pain	211	590	35.8	-
Diarrhea	423	590	71.7	-
Cough	302	590	51.2	-
Can name at least one danger sign of illness	566	590	95.9	0.3*
Can name at least two danger signs of illness	360	590	**61.0**	0.8*
Signs of dehydration:				
Sunken eyes	320	590	54.2	-
Inelastic skin	224	590	38.0	-
Decreased urine	7	590	1.2	-
Dry lips	21	590	3.6	-
Sunken fontanel	69	590	11.7	-
Thirsty	60	590	10.2	-
Can name at least one sign of dehydration	385	590	65.3	0.7*
Can name at least two signs of dehydration	229	590	**38.8**	0.7*
Illness in the past two weeks:				
Diarrhea	245	590	41.5	-
Dysentery (blood in stool)	47	590	8.0	-
Cough	231	590	39.2	-
Difficulty breathing/dyspnea	80	590	13.6	-
Fever	237	590	40.2	-
Malaria	9	590	1.5	-
Convulsions	7	590	1.2	-
Any illness within the past two weeks	392	590	66.4	-
Where advice/treatment sought for illness in past two weeks:				
No where	72	590	12.2	-
Health facility	207	590	**35.1**	0.8*
Pharmacy	2	590	0.3	-
Voodoo practitioner	7	590	1.2	-
Market	1	590	0.2	-
Machann grenn	3	590	0.5	-
TBA	11	590	1.9	-
Parents	109	590	18.5	-

Indicator	Num	Dem	Point Estimate (%)	Std. Dev.+ / C.I.*[1]
Friends	38	590	6.4	-
Child Feeding During Illness:				
Gave less liquids	160	590	27.1	-
Gave the same amount of liquids	316	590	53.6	-
Gave more liquids	114	590	**19.3**	-
Gave less to eat	205	590	34.7	-
Gave the same amount to eat	96	590	**16.3**	-
Gave more to eat	50	590	**8.5**	-
Gave less breastmilk	43	590	7.3	-
Gave the same amount of breastmilk	119	590	20.2	-
Gave more breastmilk	179	590	**30.3**	-
Oral rehydration:				
Heard of ORS	548	590	92.9	-
Knows how to prepare packet of ORS	155	590	26.3	-
Knows how to prepare 'home solution'	137	590	23.2	-
Remedy for diarrhea given during last diarrhea episode (not limited to past two weeks):				
None	41	590	6.9	-
Oral rehydration solution ('sewom oral')	153	590	**25.9**	0.7*
'Home remedy'	56	590	9.5	-
'Doctor's remedy'	78	590	13.9	-
Type of ORS given: sachet	148	590	**25.1**	0.7*
Type of ORS given: 'home ORS' ('sewom oral lakay')	10	590	1.7	-
HIV/AIDS				
Ever heard of HIV/AIDS	570	590	96.6	-
Knowledge of HIV/AIDS prevention:				
Don't know anything that one can do	97	590	16.4	-
Abstinence	27	590	4.6	-
Use condoms	243	590	41.2	-
Be faithful		590		-
Limit number of sexual partners	76	590	12.9	-
Avoid prostitutes		590		-
Avoid sex with persons who have multiple partners	94	590	15.9	-
Avoid lesbian/homosexual relations	16	590	2.7	-
Avoid sexual relations with drug users	21	590	3.6	-
Avoid blood transfusions	18	590	3.1	-
Avoid injections	16	590	2.7	-
Avoid used needles	37	590	6.3	-
Avoid kissing	6	590	1.0	-
Avoid mosquito bites	9	590	1.5	-
Take home remedies ('pran remed tradisyonel')		590		-
Avoid use of used razors or combs	50	590	8.5	-
Where/how can one go to find out if they have HIV/AIDS:				
Lab test	38	590	6.4	-
Health center	73	590	12.4	-
HIV/AIDS counseling center	4	590	0.7	-
Signs that a person may have HIV/AIDS:				
Fine hair ('cheve swa)	205	590	34.7	-
Weight loss ('lap depafini')	283	590	48.0	-
Delerious ('zona')	22	590	3.7	-
Chancre ('chank')	11	590	1.9	-
Where would the person go to get an HIV/AIDS test?				
Don't know	7	539	1.3	-
Hospital	438	539	81.3	-
Health center	90	539	16.7	-
VCT counseling center	4	539	0.7	-

Indicator	Num	Dem	Point Estimate (%)	Std. Dev.+ / C.I.*[1]
Heard of other sexually transmissible infections (STIs) besides HIV/AIDS?:				
No	219	588	37.2	-
Yes	368	588	62.6	-
Knowledge of signs of and STI in a woman:				
Don't know	53	373	14.2	-
Lower abdominal pain	56	373	15.0	-
Vaginal discharge	192	373	51.5	-
Foul-smelling discharge	85	373	22.8	-
Urinary burning	120	373	32.2	-
Erythema of the vulvae	34	373	9.1	-
Chancre/ulcer/papule	90	373	24.1	-
Bloody urine	15	373	4.0	-
Weight loss, emaciation	62	373	16.6	-
Infertility	11	373	2.9	-
Rash, itching	95	373	25.5	-
Can name at least 2 signs of an STI in a woman	212	373	35.9	0.1*
Had STI in past 12 months (self-reported)	95	364	14.0	-
Hygiene				
When hands washed:				
Before preparing meals	3	590	0.5	-
Before breastfeeding or feeding infant	240	590	40.7	-
After using the toilet	168	590	28.5	-
After cleaning child who has defecated	380	590	64.4	-
When hands are dirty	98	590	16.6	-

[1]+ = standard deviation; * = confidence interval = $\pm 2 * 1.96 \sqrt{(P*Q)/N}$

[2]May include grandmothers or other primary care givers

Draft Tri-Partite Agreement **Appendix 4**

CONTRAT TRIPARTITE

Entre :

1) Le Ministère de la Santé Publique et de la Population (MSPP) sis au Palais des Ministères, Port-au-Prince, Haïti, représenté par le Ministre Dr Henri-Claude Voltaire, propriétaire, demeurant et domicilié à Port-au-Prince, Haïti, identifié au numéro …….. ci après appelé le Ministère, (MSPP), soussigné ;

2) Les Centres pour le Développement et la Santé (CDS) représenté par le Dr Réginald Boulos, propriétaire, demeurant et domicilié à Port-au-Prince, identifié au numéro 003-185-165-5 ci-après appelé CDS, soussigné ;

3) The People-to-People Health Foundation, Inc ayant son siège social à Millwood, Virginia légalement autorisé à fonctionner en Haïti et ci-après désigné Projet HOPE représenté par ……. identifié par son passeport au numéro……., soussigné :

Il a été convenu et arrêté ce qui suit :

Article 1- Objet du Contrat et But du Programme

Le contrat a pour but de réaliser, conjointement par les trois (3) parties signataires, un programme de santé communautaire intégré dans la partie ouest du Département du Nord'Est au niveau des six (6) communes suivantes : Trou du Nord, Terrier Rouge, Caracol, Sainte Suzanne, Valières et Perches, tel que défini dans les termes de référence du DIP (Detailed Implémentation Plan) soumis à l'approbation de l'USAID, le 30 avril 2002. Il sera exécuté avec le support externe de l'USAID via Projet HOPE pour la période du ……au 28 septembre 2006.

Le but du Programme est de promouvoir et de protéger la Santé de la population des aires sélectionnées en améliorant l'efficience, la couverture, l'utilisation et la qualité des services de santé, par un changement dans la performance des acteurs du système: management des fournisseurs et prestataires de soins, des leaders communautaires et des familles. Les activités se dérouleront à 4 niveaux: Famille et Individu, Communauté, Etablissement de santé, DSNE/UCS.

Article 2- Description du Programme.

Ce programme consiste en la prise en charge d'activités médico-sanitaires incluant notamment :

- Intervention en survie de l'enfant (Prise en Charge Intégrée des Maladies de l'Enfance : PCIME)
- Vaccination,
- Nutrition,
- Allaitement maternel,
- Contrôle des Maladies Diarrhéiques,
- Gestion des cas de Pneumonies,
- Maternité sans Risque,
- Espacement des naissances,

- IST/VIH/SIDA,
- Suivi et évaluation de la Performance,
- Echanges des leçons apprises
- Recherche opérationnelle
  Développement communautaire

Ces activités seront naturellement soutenues par l'éducation, le recyclage, la supervision, la gestion, l'assistance technique, la recherche opérationnelle.

ROLE ET RESPONSABILITES DES PARTIES.

A) Rôles et responsabilités du MSPP

Article- 3 : Le MSPP sera responsable de l'exécution des prestations, objet du présent contrat. Autrement dit, le MSPP est directement responsable de la délivrance des soins et services de Santé aux populations des six communes concernées, tant au niveau des établissements de santé qu'au niveau de la communauté.

Article- 4 : Le MSPP remplira ses obligations comme prévu aux articles 5 et suivants du présent contrat et selon les normes qui permettent leur exécution avec diligence et efficacité.

Article 5 : Le MSPP agira conformément aux techniques et pratiques généralement prescrites dans le Plan National de Santé et selon les normes et standards en usage au niveau national, lesquelles seront prises en compte par DSNE en évaluant les activités du Programme.

Article- 6 : Le MSPP est responsable du recrutement, de la supervision et de la discipline du personnel affecté au projet. Il devra aussi s'assurer que le comportement dudit personnel est en tout point conforme aux normes officielles du Ministère et sanctionner ou assumer les responsabilités pour tous écarts ou dommages survenus dans l'exécution des activités de ce projet.

Article- 7 : Le MSPP préparera un rapport technique mensuel des activités pertinentes du Programme dont une copie sera régulièrement remise aux deux autres parties ainsi que les études et autres documents préparés par lui dans l'exécution de ses prestations.

Article- 8 : Le MSPP dressera tous les six (6) mois un inventaire physique des biens et équipements mis à sa disposition dans le cadre du projet et qui devront être identifiés par le logo de l'USAID. Une copie de cet inventaire pour les six communes du Programme sera remise aux deux autres parties

Article- 9 : Le MSPP est chargé de collecter et de faire parvenir au CDS au quinzième jour du mois suivant, toutes les pièces justificatives des dépenses encourues (feuilles de paie, autorisation et rapport de supervision, bon de réception de matériel…) durant le mois antérieur.

Article- 10 : Le MSPP devra s'assurer à tout moment de la disponibilité et de l'approvisionnement régulier aux différents points de prestation qui font l'objet de ce contrat. Il demeure entendu que l'acquisition des intrants subventionnés sont à la charge exclusive du MSPP et que les intrants non subventionnés proviendront des recettes internes des établissements concernés. A aucun moment le Programme ne devra être en rupture de stock.

Article- 11 : Le MSPP est responsable du paiement des émoluments et tous autres bénéfices(Assurances comprises) du personnel du Projet émargé à son budget.

Article- 12 : Le MSPP garantit aux deux autres parties l'accès libre et sans contraintes aux sites de l'aire d'exécution du Projet

Article- 13 : Le MSPP a pour obligation de vérifier les compétences des exécutants, de contrôler l'organisation et la qualité du travail fourni sur le terrain jusqu 'à l'achèvement complet des obligations régulières et contractuelles.

B) Rôle et responsabilités du CDS.

Il couvrent une gamme variée d'activités décrites dans le Projet DIP pour assurer l'implémentation du Programme, savoir : encadrement, entraînement, supervision, monitoring, gestion, assistance technique et autres, souvent en collaboration avec le MSPP

Article- 14 : Le CDS fournit au MSPP l'encadrement et l'assistance technique et administrative nécessaires à la réalisation de ses activités dans le cadre du Projet et veille à ce que ces activités soient réalisées telles que programmées de concert avec les deux autres parties.

Article- 15 : Le CDS a la responsabilité de la gestion des fonds du Projet, en conformité avec les normes et standards de l'USAID et du Projet Hope.

Article- 16 : Le CDS participe aux côtés du MSPP à toutes les phases du Projet
(Planification, Organisation, Supervision et Evaluation) et à tous les niveaux :
Famille/Individu, Communauté, Etablissement de Santé, DSNE/UCS.

Article– 17 : Le CDS s'assure de la tenue régulière des réunions techniques et administratives qui doivent être organisées tous les deux mois pour personnel local et, d'un commun accord avec le MSPP, fixe les dates des réunions trimestrielles auxquelles les parties signataires de ce contrat assisteront ou se feront représenter. Toutefois, le CDS peut, à tout moment, provoquer une réunion à l'extraordinaire que rendrait nécessaire le monitoring du Projet.

Article – 18 : Le CDS attirera l'attention du MSPP, en vue de redressement, sur toutes anomalies relevées soit en cours de supervision, soit à l'occasion de l'analyse des rapports techniques et administratifs.

Article- 19 : Le CDS collabore avec le Projet Hope dans la planification et l'exécution du monitoring et de l'évaluation des activités du Programme et est responsable de la communication des résultats à tous les participants.

Article – 20 : Le CDS est responsable avec Projet Hope de la diffusion, tant sur le plan national qu'international des résultats et des leçons tirées du projet.

Article- 21 : Le CDS prépare et émet les chèques de salaire et autres bénéfices du personnel non émargé au budget de MSPP. La distribution en sera assurée par le MSPP.

Article- 22: Le CDS a pour mission d'exécuter, dans le plus bref délai, les réquisitions qui lui sont soumises par le MSPP pour l'acquisition de biens ou services nécessaires à la bonne marche du Projet. Ces réquisitions seront exécutées en fonction des normes et standards de l'USAID.

Article- 23 : Le CDS veillera à ce que soient réalisés, une fois par an, l'inventaire physique et l'audit financier du Projet.

Article- 24 : Le CDS a la responsabilité d'informer régulièrement Projet HOPE sur la marche et l'évolution des activités du Programme incluant un rapport mensuel d'activités et de progrès, avec un plan d'activités à court terme des rapports trimestriels et annuels de performance et d'accomplissement du Programme et de lui faire parvenir copie de tous les rapports intéressant ledit Projet. Un rapport financier mensuel avec copie des pièces justificatives sera préparé à cette fin ainsi que le rapport d'inventaire et d'audit annuel.

C) **Rôle et responsabilités du Projet HOPE**

Article- 25 : En tant que receveur des fonds du projet, HOPE est responsable par devant l'USAID de l'implémentation effective des activités et doit s'assurer des décaissements et de l'utilisation appropriés des fonds. Cette responsabilité et cette imputabilité supposent que HOPE s'implique tant dans le suivi des activités du Projet que dans les rapports des autres partenaires.

Article- 26 : HOPE est responsable de l'interaction avec l'USAID incluant: la soumission d'un rapport financier et technique trimestriel, la soumission des documents techniques dont: le Plan d'Implémentation Détaillée (DIP), l'Etude des connaissances, attitudes et pratiques (KPC) de la population au début et en fin de projet, un rapport d'évaluation à mi-parcours et tous autres documents produits en collaboration entre les trois partenaires.

Article- 27 : HOPE est responsable de la révision des outils, curricula, plan, autres matériels et documents techniques préparés en Haïti et fournissant des conseils et recommandations opportuns et adaptés aux besoins du projet de façon à en assurer l'appropriation et l'efficacité. De son côté le CDS, est responsable de la dispensation à l'avance des articles et plans qui seront utilisés de façon à en permettre la révision et l'incorporation des recommandations formulées dans les activités du projet.

Article- 28 : HOPE s'engage à rechercher et à rendre disponibles de manière opportune les fonds tels que prévus dans le budget susmentionné.

Article- 29 : HOPE s'engage à fournir, au besoin, au CDS toute assistance lui permettant de mieux exécuter les tâches qui lui incombent dans le cadre du Projet.

Article- 30 : HOPE est responsable tant indépendamment qu'à travers le CDS de l'implémentation du projet selon le DIP et le budget approuvé. HOPE doit approuver tout changement d'activités du projet qui ne serait pas en accord avec le DIP ou le budget approuvé. Dans certains cas, ces modifications peuvent requérir l'pprobation additionnelle de l'USAID.

Dr Henri-Claude Voltaire
Ministre de la Santé Publique
Et de la Population (MSPP)

Dr Réginald Boulos
Président Conseil d'Administration
Centres pour le Développement
et la Santé (CDS)

……
……People to People
Health Foundation, Inc (HOPE)

Appendix 5

PROJECT MSPP / HOPE / CDS
Workplan

October 2003 to September 2003

1.- TRAINING (promoters, personnel and staff)

ACTIVITY	RESPONSIBLE	TIME FRAME											
//	//	O	N	D	J	F	M	A	M	J	J	A	S
1.1.- 46 Promotors and AS (Group I, from TDN and TR)	**DSNE, CDS, HOPE**												
• Diarrhea	Nurses	X											
• ARI	Nurses	X											
• Tuberculosis	Dr Frederique		X										
• Community Mobilization	Nurses		X										
1.2.- 48 Promotors and AS (Group 2 from 4 communes: Ste Suzanne, Vallieres, Caracol, Perches)	**DSNE, CDS, HOPE**												
• Census	Institut Haitien de Statistique				X								
• Community Approach and IEC	Nurse trainers				X								
• Immunization	Nurse trainers				X								
• Nutrition	Nurse trainers					X							
• Family Planning	Nurse trainers					X							
• Breastfeeding	Nurse trainers					X							
• Maternal Health	Nurse trainers						X						
• STI / HIV / AIDS	Nurse trainers						X						
• Community based HIS	Statistician and Dr Benoit							X					
• Diarrhea	Nurse trainers							X					
• ARI	Nurse trainers							X					
• Tuberculosis	Dr Frederique								X				
• Community Mobilization	Nurse trainers								X				
1.3.- Auxiliaries and nurses	**DSNE, CDS, HOPE**												
• 12 aux and nurses in PCIME	Dr Sabine Lustin								X				
• 28 aux and nurses in Reproductive Health Norms	Nurse trainers								X				
• 28 aux and nurses in Family Planning	Nurse trainers							X					
• 28 aux and nurses in STI / HIV / AIDS	Nurse trainers							X					
• 28 aux and nurses in Community mobilization and outreach, adult education and IEC	Nurse trainers							X					
• 28 aux and nurses in Supervision													
1.4.- DSNE , UCS and Facility staff	**DSNE, CDS, HOPE**												
• Supervision	MSH											X	
• Capacity Building	CDS						X						
• Management / M&E / Community HIS	CDS (stat., Benoit, JM, LB)							X					

2.- TRAINING (Community organizations and members in 2 groups)

ACTIVITY	RESPONSIBLE	TIME FRAME											
2.1.- Mother's and father's clubs, and VHC (Group 1 area)	**DSNE, CDS, HOPE**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**
• Preparation of Health Curricula (Immunization, Nutrition, Vit A, Child weighing, Dehydration, Diarrhea, ORS, PF, Prenatal cares, Sick Child management, Breastfeeding, STI/HIV/AIDS, Organizing Fixed Points and Rally Post + Implementation, Data interpretation of the HIS	DSNE / CDS / HOPE				X	X							
• Training + Implementation	Auxiliaries and promotors						X	X	X	X	X	X	X
• Supervision (Visit and Meeting)	Auxiliaries and promotors						X	X	X	X	X	X	X
2.2.- 30 Animatrices in breastfeeding	**DSNE, CDS, HOPE**												
• Recruit Animatrices and training	Community and Auxiliaries		X	X	X	X	X	X	X				
• Implementation and Supervision										X	X	X	X
2.3.- Traditional Birth Attendant (TBA) [50%)	**DSNE, CDS, HOPE**												
• Inventory of TBA / Adaptation of Curriculum	Promotors, DSNE/CDS/ HOPE	X	X	X	X								
• Birth attendance	Aux					X	X	X	X	X	X	X	X
• Breastfeeding	Aux					X	X	X	X	X	X	X	X
• Family Planning	Aux					X	X	X	X	X	X	X	X
• SIT / HIV / AIDS	Aux					X	X	X	X	X	X	X	X
2.4.- Community based Distribution (CBD) [50%]	**DSNE, CDS, HOPE**												
• Adaptation of CBD Curriculum	CDS				X	X	X						
• Choice of the places	Community / Promotors					X			X				
• Training	UCS nurses								X	X	X	X	X
• Supply / resupply and Supervision	UCS nurses									X	X	X	X
2.5.- Organizations and Traditional leaders													
• Inventory	promotors		X	X	X	X							
• Preparation of Curricula (Immunization, Nutrition, Vit A, Child weighing, Dehydration, Diarrhea, ORS, PF, Prenatal cares, Sick Child management, Breastfeeding, STI/HIV/AIDS + Implementation	DSNE /CDS /HOPE				X	X							
• Training	Auxiliary, Promotors						X	X	X	X	X	X	X
• Supervision (Visit and Meeting)													
2.6.- COSAM and HEARTH													
• Recruiting	Promotors				X	X	X	X	X				
• Training and Supervision	Aux and Promotors									X	X	X	X

3.- CENSUS (Group 2: Ste Suzanne, Caracol, Perches and Vallieres)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
3.1.- Meeting with community leaders and organizations	UCS, Facility Staff	X	X										
3.2.- Selection of promoters, based on criteria	UCS, facility Staff			X									
3.3.- Training on Census	Institut Haitien de Statistique				X								
3.4.- Mapping	Institut Haitien de Statistique				X								
3.5.- Census and Numbering houses	Promotors and Volunteers				X	X							
3.6.- Census Analyis	Ing …					X	X	X					

4.- FIELD ACTIVITIES (Community)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
4.1.- Mother's and father's clubs and VHC (Group 2 area)													
• Organize and conduct fixed points and rally posts	community									X	X	X	X
• Realize domiciliary visit	community									X	X	X	X
• Participate actively and regularly in health meeting	community									X	X	X	X
• Demonstrate knowledge & practices at target level	community									X	X	X	X
.2.- 30 Animatrices in breastfeeding													
• Demonstrate knowledge in educating and supporting mothers in breast feeding	community									X	X	X	X
• Participate at fixed points, rally post and meetings	community									X	X	X	X
• Realized domiciliary visit	community									X	X	X	X
4.3.- Traditional Birth Attendant (TBA) [50%)													
• Make safe birth delivery	community									X	X	X	X
• Demonstrate knowledge in PF, BF, STI/HIV/AIDS	community									X	X	X	X
• Be present at continuous training session at the facility	community									X	X	X	X
4.4.- Community based Distribution (CBD) [50%]													
• Supply and resupply the CBD	auxiliary, promotor												
• Promote products (ORS, Planning methods, etc.)	CBD												
4.5.- Organizations and Traditional leaders													
• Realize domiciliary visit	community												
• Participate actively and regularly in health meeting	community												
• Demonstrate knowledge & practices at target level	community												
•													
4.6.- COSAM and HEARTH													
• Participate actively and regularly in health meeting	community												
• Demonstrate knowledge & practices at target level	community												

4.- FIELD ACTIVITIES (Promotors)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
4.1.- Realize and conduct rally post and fixed points with the community where the following activities are taking place: Immunization, Child weighing, Family Planning, collective and individual education on PF, STI, Breastfeeding, ORT/ORS (*sel lavi),* Nutrition, management of sick child, etc…)	Promotors		X	X	X	X	X	X	X	X	X	X	X
4.2.- Realize domiciliary visit (post natal, to track defaulters etc…)	Promotors		X	X	X	X	X	X	X	X	X	X	X
4.3.- Organize and participate at community meeting (for education, training purposes, to give feedback and information etc..)	Promotors		X	X	X	X	X	X	X	X	X	X	X
4.4.- Organize and facilitate ongoing training sessions for community members and organizations	Promotors								X	X	X	X	X
4.5.- Collect data, write report	Promotors		X	X	X	X	X	X	X	X	X	X	X
4.6.- Participate in regular training sessions at the facility	Promotors		X	X	X	X	X	X	X	X	X	X	X
4.7.- Supervise & facilitate the activities of the VHC	Promotors								X	X	X	X	X
4.8.- Supervise CBD activities	Promotors				X	X	X	X	X	X	X	X	X

4.- FIELD ACTIVITIES (Auxiliaries)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
4.1.- Participate at the fixed points activities; give services: prenatal care, collective & individual education, FP examinations, Rx.)	Auxiliary		X	X	X	X	X	X	X	X	X	X	X
4.2.- Supervise promoters, VHC, CBD	Auxiliary		X	X	X	X	X	X	X	X	X	X	X
4.3.- Realize selective domiciliary visit	Auxiliary		X	X	X	X	X	X	X	X	X	X	X
4.4.- Organize and participate at training sessions	Auxiliary								X	X	X	X	X
4.5.- Supply and resupply fixed points with drugs and supplies	Auxiliary				X	X	X	X	X	X	X	X	X
4.6.- Collect data and write reports	Auxiliary		X	X	X	X	X	X	X	X	X	X	X
4.7.- Give feedback to promoters and community	Auxiliary		X	X	X	X	X	X	X	X	X	X	X

4.- FIELD ACTIVITIES (Facility and UCS)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
4.1.- Supervise the activities at fixed points and rally posts	Facility, UCS		X	X	X	X	X	X	X	X	X	X	X
4.2.- Organize and participate at training sessions	Facility, UCS		X	X	X	X	X	X	X	X	X	X	X
4.3.- Supply auxiliaries with drugs and supplies for fixed points and rally posts	UCS				X	X	X	X	X	X	X	X	X
4.4.- Give feedback to auxiliaries and the community	Facility, UCS			X	X	X	X	X	X	X	X	X	X

5.A. MANAGEMENT & CAPACITY ASSESSMENT (DSNE and UCS)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
5.1.- Develop interview form	CDS (technical staff)			X									
5.2.- Review interview form	CDS (technical staff)				X								
5.3.- Test interview forms	CDS (technical staff)				X								
5.4.- Interview DSNE, UCS Staff	CDS (technical staff)					X							
5.5.- Analyze the assessment	CDS (technical staff)					X	X						
5.6.- Write report	CDS (technical staff)							X					
5.7.- Meeting with DSNE, UCS to discuss result and plan actions	CDS (technical staff)								X				

5.B. MANAGEMENT & CAPACITY ASSESSMENT (CDS Central)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
5.1.- Develop interview form	MSH or Other Institution			X	X								
5.2.- Review interview form	MSH or Other Institution					X							
5.3.- Test interview forms	MSH or Other Institution					X							
5.4.- Interview CDS Staff	MSH or Other Institution						X						
5.5.- Analyze the assessment	MSH or Other Institution						X	X					
5.6.- Write report	MSH or Other Institution								X				
5.7.- Meeting with CDS central staff to discuss results and plan actions	MSH or Other Institution									X			

6.- MONITORING AND EVALUATION

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
6.1.- Collecting data	At different levels		X	X	X	X	X	X	X	X	X	X	X
6.2.- Analyze data	DSNE / CDS / HOPE		X	X	X	X	X	X	X	X	X	X	X
6.3.- Write report	DSNE		X	X	X	X	X	X	X	X	X	X	X
6.4.- Prepare wall chart (for each program)	Facilities		X	X	X	X	X	X	X	X	X	X	X
6.5.- Feedback (facility, community)	DSNE, Facilities, Promotor		X	X	X	X	X	X	X	X	X	X	X
6.7.- Redefine plan and strategies	At different level (Community, UCS, Facility, DSNE)		X	X	X	X	X	X	X	X	X	X	X

7.- SUPERVISION

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
7.1.- Develop/test supervision checklist & problem solving methods	CDS (Technical Director)	X	X										
7.2.- Train CDS staff in use, training, mentoring	CDS (Technical Director)		X	X									
7.3.- Train UCS, DSNE staff	CDS field staff				X								
7.4.- Conduct supervision/problem solving with mentoring by CDS staff	CDS field staff, UCS & DSNE staff					X	X	X	X	X			
7.5.- Conduct independent supervision	UCS & DSNE staff								X	X	X	X	X
7.6.- Train promotors in facilitation, supervision, problem solving at community level	CDS field staff, auxiliaries					X	X						
7.7.- Promotors conduct facilitation, supervision, problem solving with mentoring	CDS field staff, auxiliaries, promotors						X	X	X				
7.8.- Promotors conduct independent facilitation, supervision, problem solving	promotors							X	X	X	X	X	X

8.- MANAGEMENT

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
8.1.- Weekly telephone/vClass review CDS/HOPE	RSN, PPD, JM	X	X	X	X	X	X	X	X	X	X	X	X
8.2.- Monthly written activity and progress report	JM	X	X	X	X	X	X	X	X	X	X	X	X
8.3.- Weekly meeting Field team & DSNE managers	JM, PJD	X	X	X	X	X	X	X	X	X	X	X	X
8.4.- Monthly HIS/monitoring data review by CDS, UCS, DSNE	JM, Benoit, PJD, UCS nurses	X	X	X	X	X	X	X	X	X	X	X	X
8.5.- Quarterly in depth HIS/monitoring data & progress review	DSNE, MOH, CDS, HOPE				X			X			X		
8.6.- Monthly financial report to CDS, HOPE		X	X	X	X	X	X	X	X	X	X	X	X
8.7.- Preparation for Mid-Term Review											X	X	X
8.8.- MidTerm Review													X